TRRx Request for Proposals Questions and Answers
5/08/03

NOTE: This set of Questions and Answers, originally posted April 30, 2003 is updated to provide responses to questions 290 and 296. All other responses remain unchanged.

Question 251. Reference PDTS ICD, Transaction Rejected Response (Header Reject) page 37. The record format for this response indicates that the NCPDP ID and date of service will be included along with the reject status, but no other information identifying the original record submitted. It is conceivable there could be multiple POS submissions on the same day. Since an ICN is not added to the record until PDTS sends a TED to TMA, how will TRRx identify which transaction is rejected?

Response 251. TRRX will receive a duplicate file of what is submitted for payment to TMA. The file format, layout, transmission requirements etc will be agreed upon during the implementation phase following Contract award.

Question 252. Reference Q&A #13. The question asked about the Governments risk assessment regarding the national TRRx implementation directed offerors to request a copy of the document through the filing of a FOIA request, which by most accounts, would not be made available during the proposal submission period. With the understanding that the Government desires to develop a partnership with all contractors, and assuming this decision paper may have important risk assessments that could be helpful to an offeror, we request that this document be made available to all potential offerors without FOIA. Thank you.

Response 252. The requested document will not be made available as it contains additional procurement sensitive information not related to the question. However, the Government, during the acquisition-planning phase of TRRx, evaluated risks associated with the technical, cost and schedule aspects of the acquisition. From a technical perspective, the risk was considered low. The procurement is for retail pharmacy operations, in which there is extensive commercial expertise in existence. Services provided by the successful offeror will substantially mirror existing industry practices. From a cost perspective, the Government's risk is in the ability of the successful offeror to maintain the guaranteed network discount and dispensing fee, thereby keeping the costs of pharmaceuticals under control; hence, the incentive/negative incentive provisions of the solicitation and the requirements of the successful offeror to have not only the technical capability to perform, but also the financial capability. From a schedule perspective, based upon historical and current experience in retail and mail-order pharmacy implementation, as well as recommendations from industry consultants, the six-month implementation period is adequate. A national, versus a regional, implementation is an acceptable risk considering the simplicity and portability afforded the beneficiaries in a national benefit.

Question 253. Reference Q&A #17 (f) and #134. These questions request information about the paper claims quantities. Considering the answer to question #17 that provided historical data indicating that 3% of pharmacy claims are received in paper, will the Government be amending the RFP volumes in Section B?

Response 253. Yes. Clarification and updates to prescription quantities are provided at Amendment 0002.

Question 254. Reference: Q&A #19 and #20. Please confirm the outgoing MCSC will handle all post TRRx implementation pharmacy adjustments and creation of HCRS and/or TEDS for claims originally processed by the MCSC.

Response 254. The Outgoing contractor is responsible for HCSRs for all claims they have processed, including corrections & resubmission. See the excerpted guidance from the Managed Care Support Contractor Operations Manual, applicable to the MCSCs below:

OPM Chapter 1, Section 8, Para. 5.3.10 Correction of Edit Rejects.

> The outgoing contractor shall retain sufficient resources to ensure correction (and reprocessing through TMA) of all health care service record edit errors not later than 210 calendar days following the start of the incoming contractor's health care delivery.

Question 255. Reference Q&A #17 and #48. Both of these questions requested the Government to provide key historical contract volumes. The Government has stated the information is not available. We believe that TRICARE incumbent contractors do have these historical volumes and therefore have a distinct incumbent advantage. Would the Government survey the current MCSC and request this data and then make it available to the TRRx offerors?

Response 255. The data is not available to the Government. Given the timing of this procurement, we are unable to request the data from the MCSC contractors. Given the program differences between existing retail pharmacy services and those contemplated under this solicitation, the Government does not believe any substantial benefit accrues to the MCSC contractors.

Question 256. Reference Q&A #58, #97 and #98. The Q&A references the contractors use of "SelectRX". We have been unable to locate any references and/or instructions concerning the use of SelectRX. Please provide any RFP references or provide amendment instructions to assist us to understand the SelectRX requirements.

Response 256. SelectRx is a proprietary system of PDTS. The Government will provide SelectRx software and training to the successful offeror following award. SelectRx is the software used to access PDTS.

Question 257. Reference Q&A #112 and #93. For paper claims, eligibility will be determined with the nightly demographic download from DEERS. Answer to Q#93 states that C.8.1 will be amended to revise this requirement so that the contractor will not

have to receive the demographic download or retransmit demographic data. Please clarify the answer to these two questions.

Response 257. We apologize for the confusion. The nightly demographic download from DEERS will allow PDTS to complete the TED records for each prescription. Eligibility for paper claims will be completed through an eligibility only inquiry prior to the contractor processing the claim.

Question 258. Reference Q&A 122. The answers to Q122 are not clear, and we request further clarification.

a. Please provide some examples of the type of case where a beneficiary may obtain an override.

b. Stating, "some form of documentation from the beneficiary" is not clear. Will the Government expect the beneficiary to provide a letter, email or other form of documentation stating they have no other coverage? How and by whom is the information provided to be verified?

c. Based on this answer, the MCSC can change the OHI status for a beneficiary while the claim is in process with the TRRx. Will the OHI indicator have one or more indicators, i.e. one for MCSC and one for Rx? We see a system conflict issue.

d. Is this process specific to MCSC, and not affect TRRx?

e. The Government response said "no" to the question regarding Medicare CWF. We encourage TMA to investigate the possibility to add this feature to the TRRx processing.

Response 258. a. On a case by case basis, an override may be granted with a verbal statement from the beneficiary that they do not have an OHI pharmacy benefit. For example, a beneficiary going on vacation very soon, or an instance where the beneficiary needs the prescription on an emergency basis.

b. The beneficiary may provide a written statement that they do not have any OHI. Alternatively, the beneficiary may provide their OHI coverage documentation that demonstrates no pharmacy coverage, or provide an EOB from their OHI that they have exhausted their pharmacy benefits.

c. The OHI indicator will indicate pharmacy coverage. Simply having OHI does not preclude a beneficiary from coverage under TRRx if there is no pharmacy coverage or if the beneficiary has demonstrated their pharmacy coverage has been exhausted.

d. Yes. This requirement is in support of obtaining accurate OHI data.

e. Thank you for your suggestion. We will consider this following award.

Question 259. Reference the TMA cutoff for questions as of 4/14/03. Will the government please accept additional clarification questions on responses to questions posted after 4/14/03?

Response 259. Additional time to submit questions may be granted at the discretion of the Contracting Officer.

Question 260. What percentage of claims were rejected by TRICARE post-dispensing for 2002 or the most recent 12 month period? In the current environment, how many (or what percentage of those claims) rejected due to contractor error, PDTS-related error and other related causes, respectively?

Response 260. The percentage of claims rejected after being dispensed is not available to TMA. Rejections caused by PDTS would only relate to clinical issues, i.e., adverse interactions, too soon refill, etc. Data on other causes of rejection are not available to TMA.

Question 261. In TRICARE's view, are there any significant differences in the T-RRx claims processing and review protocols that may result in significantly different reject rates?

Response 261. It is not anticipated that the reject rates will be "significantly" higher. One can only assume that the reject rates would be slightly higher given the fact that all transactions from all points of service are consolidated onto one profile for each unique utilizer.

Question 262. Reference Question Response #122 and Conference Transcript pages 70&71. Question #122 c and transcript pages 70&71 indicate that the MCSC can re-set the flag for OHI after it was cleared from the PDTS data base. Presently the MCSC sets the OHI indicator on DEERS.

a. Does the government expect the MCSC to update the PDTS pharmacy OHI indicator?

b. Or, in setting the DEERS OHI indicator will the PDTS pharmacy OHI indicator set automatically?

If the latter, it is feasible that while a claim is in process with TRRx/PDTS after the PDTS data base indicator has been cleared, that a MCSC transaction updating DEERS OHI could reset the PDTS pharmacy OHI indicator causing the already processing claim to reject when further editing occurs. Please clarify.

Response 262. OHI data will be maintained by PDTS until such time as DEERS is ready to assume that function. OHI data will be provided to PDTS by the MCSC until DEERS assumes responsibility for providing OHI data. Once testing at DEERS is complete and it has been confirmed that OHI data is populated at DEERS and does include a pharmacy benefit indicator, responsibility for OHI data will transfer to DEERS. Your concerns will

be addressed in discussions with DEERS as business rules are developed for DEERS serving as the centralized data repository for OHI information.

Question 263. Do other circumstances exist under which the Government would consider not requiring the guarantee reference in L.10.2.3, such as when the Offeror has demonstrated adequate financial resources and total equity greater than the contract value?

Response 263. No.

Question 264. Section L.10.2.3 indicates that DLA Form 621 is the preferred format for the guarantee. Would other formats be deemed responsive? If so, what other formats or what material provisions must the guarantee contain, to be deemed responsive?

Response 264. No. Offerors shall use the DLA Form 621. An electronic version of the form has been added at Attachment 20-L via Amendment 0002.

Question 265. Would a parental guarantee that establishes a ceiling or limit on the amount of the guarantee be deemed responsive provided that the established amount is sufficient? If the answer to the previous question is yes, what in the Government's view would be sufficient ceiling or limit?

Response 265. No. The parent must guarantee full and complete performance in accordance with the terms and conditions of the solicitation and resulting contract.

Question 266. At the Pre Proposal Conference, guidance was given regarding the fraud and abuse plan and managing beneficiaries with drug seeking behavior, page 55 of the transcript. Will the sanction process of single provider or single pharmacy, etc. reside in PDTS or in the contractor's system.

Response 266. The sanction process will reside with the contractor. The sanction process is likely to be initiated by the Health Care contractor and communicated to TMA for coordination of establishing a flag on PDTS applicable across all points of service. Identification of potential beneficiaries with drug seeking behavior by the TRRx Contractor would likewise be coordinated with the Health Care Contractor to determine if a flag is recommended on PDTS.

Question 267. The TRRx contractor is required to process paper claims resulting from various causes such as OHI, non-network pharmacies, or beneficiary submissions. Schedule B lists a separate CLIN for paper claims. Paper claims are excluded from total network reimbursement cost. To support these differences, how shall the TRRx contractor's transaction to PDTS distinguish between paper and electronic sources?

Response 267. Variable fields and values available within the standard NCPDP 5.1 transaction will be used for this purpose. The fields and values will be assigned during the implementation phase of the contract following award.

Question 268. In regards to the paper claim volume addressed in question 35, is the 3% of total pharmacy claims inclusive of MTF and TMOP claims. In CY 02, what percent of retail pharmacy claims were paper?

Response 268. The paper claims volume does not include MTF or TMOP claims. The Government has reviewed the projected volumes and revised them based on experienced data from March 02 through February 03. During this period, for retail pharmacy services only, there were 828,875 paper claims with 3,398,216 prescriptions, averaging four prescriptions per paper claim. During this time period, there were 30,135,421 retail pharmacy electronic claims. Approximately 10.13% of all retail pharmacy prescriptions dispensed are submitted on paper claims. Further, approximately 2.47% of all retail pharmacy claims are paper claims. Revised volumes are incorporated into the solicitation via Amendment 0002. This data supercedes previously released data.

Question 269. Section C.11 requires the TRRx contractor to submit prior authorization approvals and denials to into PDTS. Schedule B lists a CLIN for prior authorization determinations. In commercial PBM practice, approved prior authorization requests involve the PBM staff entering an over ride into the PBM system. Over rides are not entered for denied requests. Will CLIN for denied prior authorization be funded by TMA? How shall the TRRx contractor submit a denied prior authorization into PDTS?

Response 269. A denied prior authorization will be provided to PDTS in accordance with the PDTS ICD at Section J, Attachment 4. An administrative fee will be paid for denied prior authorizations and medical necessity reviews based on the data submitted to PDTS and the resultant TED.

Question 270. In the government's response to question 1.d.3 it was stated that claims from specialty pharmacies will not be applicable to the calculation of total actual network reimbursement cost. How will the government determine specialty pharmacy claims?

Response 270. Reimbursement for specialty pharmacy claims will be in accordance with the contractors network agreements with the specialty pharmacy.

Question 271. Some state and local governments apply sales tax or surcharges to prescription drugs. Will sales tax or surcharges be excluded from the calculations of the actual network reimbursement cost?

Response 271. Yes.

Question 272. C.8.7 refers to the TRRx contractor processing paper claims submitted on DoD 2642 forms. In many cases the DoD 2642 and cash register receipts will not fulfill data requirements for PDTS transactions. Is it the government's desire for these claims to be denied asking the beneficiary to submit all required data? If not what will be the governments defined 'default values" for the critical data elements requires to pass editing requirements.

Response 272. Government defined "default values" will be established in post award discussions to enable processing of prescriptions submitted on a DD 2642 that includes supporting data meeting the submission requirements to process a claim for reimbursement, but may not contain all of the data elements that would be required for an electronic claims submission from a pharmacy. Submittal of the data to PDTS will be via NCPDP version 5.1. The flexibility and variability of this standard will allow the Government to change certain fields commonly not available on the 2642 from a "required" field to a "captured" field.

Question 273. Use of default values as addressed above will lead to conflicts in some cases. The industry standard approach to direct member reimbursement utilizes a Universal Claim Form (UCF). The UCF is compliant with NCPDP transactions. Would the government allow use of the UCF for beneficiary submitted claims?

Response 273. No. The Government desires to minimize the number of claims forms to which a beneficiary is exposed. The DD 2642 is a standard claim form for TRICARE beneficiaries to use across all types of health care.

Question 274. H.2.2 refers to the calculation of the actual network reimbursement cost by applying the AWP that is in effect when the prescription is processed. Which AWP reference source will the government be using for the calculation? How often will this reference be updated?

Response 274. The data source that PDTS uses is First Data Bank. The file is updated weekly.

Question 275. Question 117 addressed the Uniform Formulary's applicability to the TRRx contract. Should contractors include costs for implementation of the Uniform Formulary in their TRRx proposals?

Response 275. Yes, in accordance with the currently published draft rule available through the Federal Register.

Question 276. In some cases beneficiaries may be charged a copay that results in the pharmacy receiving more than the negotiated rate. For example assume U/C $12, Copay $9, negotiated rate $7.50. In this case, will the actual network reimbursement cost for incentive calculations be the negotiated rate? If not, what is the basis for the incentive calculation?

Response 276. In this case, the beneficiary would be charged $7.50, and there would be no further reimbursement to the pharmacy. The incentive calculation would reflect the lower cost to the Government, to the contractor's advantage.

Question 277. In Paragraph L.8.2. the government specifies how the offeror is to disperse the beneficiary population; however, the paragraph is silent on the required

method of assigning locations to the pharmacies. There are several options for locating the network pharmacies. Can it be assumed that GeoAccess's representative geocoding methodology would be the same as that used for dispersing the beneficiary population? If not, will the government specify the method to be used for locating the pharmacies?

Response 277. Since the contractor knows the exact location of each pharmacy in its network, it should be able to determine its access levels by comparing the dispersed population to the actual locations of its network pharmacies.

Question 278. M.6.4. identifies the items to be evaluated for Factor 4 – PBM Operations which is the oral presentation. Paragraph M.6.4.4. Sub factor 4 – Management - states "The Government will evaluate the offeror's procedures for auditing its internal and external operations, identifying gaps in performance, and adjusting processes to correct identified deficiencies." L.8.5.4 Sub factor 4 – Management - does not indicate that these topics should be included in the oral presentation for Subfactor 4. However, for Factor 3 instructions, paragraph L.8.4.2. Sub factor 2 – Quality Assurance Plan - states that the plan should discuss "…problem prevention, detection and correction, …" and that "The plan shall also describe in detail the offeror's pharmacy audit procedures." Factor 3 evaluation instructions in paragraph M.6.3.2. Subfactor 2 – Quality Assurance Plan - indicates the Government will evaluate "…problem detection, correction and prevention, pharmacy audit procedures …". L.8.1. states "Offerors shall not address sub factors to be proposed in writing in their oral presentation nor shall they present sub factor information in their oral presentation that are to be proposed in writing" and L.8.5.6.2 states "Only Evaluation Factor 4 (sic) and its sub factors listed above shall be discussed in the oral presentation. The offeror shall not describe its approach or processes for meeting any other requirements."
a. Will the Government evaluate the procedures cited above from M.6.4.4. on the basis of information submitted in the Quality Assurance Plan?
b. Does the Government expect quality control and audit procedures to be included in the oral presentation?

Response 278. a. The contractor shall address its Quality Assurance plan under the written proposal as specified in Section L.8.4.2.

b. In its oral presentation, the contractor shall address the management aspects specified in L.8.5.4. Normal management responsibilities would include management oversight of the Quality Assurance program, its effectiveness and responsiveness to identified issues.

Question 279. In Paragraph L.8.2 of the RFP the government has asked that we "… identify, by urban, suburban, and rural categories, the total number of beneficiaries (unique number of eligible beneficiaries who will have to change pharmacies in order to use the offeror's proposed TRRx network." We have questions related to meeting this requirement:

a) The data provided in Attachment 16-L gives the pharmacy and the number of unique beneficiaries served by that pharmacy. The data does not enable us to know the

category of the beneficiary users or to identify beneficiaries who may have used multiple pharmacies.

i. Is it acceptable to simply assign all beneficiaries who used a pharmacy to urban, suburban, or rural based on the location of the pharmacy?

ii. Is it acceptable to report the number of unique beneficiaries as the sum of the number of unique beneficiaries across all pharmacies? This will overstate the number of actual unique users.

b) Of the 44,252 used pharmacies in Attachment 16-L, over 1000 are not in the current NCPDP list of pharmacies. These pharmacies have either closed or changed NCPDP ID numbers. (For those with new NCPDP IDs we have found that usually ownership and pharmacy named have changed.) Since an NCPDP ID match is required to identify the pharmacy, is it acceptable to eliminate the unmatched pharmacies from the analysis of disruption? If not, will the government provide the addresses for these pharmacies at the time they were being used.

Response 279. a. i. Yes. ii. The Government would expect that the number of affected beneficiaries would be provided by zip code.

b. Yes, it is acceptable to eliminate pharmacies that no longer exist from the disruption analysis. The contractor is still required to meet overall network access standards.

Question 280. C.8.8.2 states that 100% of electronic claims must be processing within 5 days. A response to a question about this standard, states that this time would include time for processing the prior authorization or medical necessity determination. It is uncertain when a claim is denied for prior authorization, if a request will be made to obtain an authorization. A second claim would be received after the prior authorization or medical necessity determination is established. How would this time be included with the original claim?

Response 280. The second claim would be processed separate from the original denied claim and would have its own timeliness standard applied.

Question 281. G.1.1.3 states that non-network pharmacies should be paid billed charges less copays and deductibles. Does this mean that AWP would not be considered in this calculation?

Response 281. That is correct.

Question 282. Who determines U&C?

Response 282. The U&C is the normal pharmacy U&C charged its customers.

Question 283. Assume the following hypothetical prescription:
U&C = $10.00
AWP = $9.25
Sales Tax = $.25

AWP less guaranteed discount plus sales tax plus guaranteed dispensing fee = $8.00
The network pharmacy receives a $9 copay from the beneficiary and no other payment

For purposes of the incentive calculation described in Sections H.2.2 and H.2.3:

a) For this claim, what is the total actual network reimbursement cost?
b) For this claim, what is the total reimbursement cost that would have resulted from applying the Guaranteed Average Discount Percentage and the Guaranteed Average Dispensing Fee per Prescription?

Response 283. a. Your example is in error. The network pharmacy would not have received a $9 co-pay. The pharmacy would actually receive an $8 co-pay, the actual cost of the prescription. The pharmacy reimbursement cost is $8, wholly paid by the beneficiary. For purposes of the incentive provision of H-1, co-pays are not included in the computation of the incentive.

b. Total reimbursement cost calculated by the Government would be $8.00. The beneficiary paid the entire cost since the prescription was for a brand drug and the cost was less than the brand co-pay. The pharmacy cannot receive co-pays in excess of billed charges.

Question 284. For purposes of clarification, assume the following claims experience and no guaranteed dispensing fee:

a. Option Period 1

	AWP	Guaranteed Discount		U&C	Allowed
	(a)	(b)			(a-b)
Claim 1	100	15	85	90	85
Claim 2	100	15	85	80	80

b. Option Period 2

	AWP	Guaranteed Discount		U&C	Allowed
	(a)	(b)			(a-b)
Claim 1	100	17.5	82.5	90	85
Claim 2	100	17.5	82.5	80	80

What is the final result of the incentive calculation for the 2 Option Periods?

Response 284. The incentive is calculated on the entire benefit and reimbursement structure. The end result will be determined based on the difference between the actual cost to the Government and the contractors proposed cost to the Government. Your question is based on an assumption that there is not a guaranteed dispensing fee. We cannot provide an answer based on an assumption contrary to the requirements of the solicitation.

Question 285. Assuming that Claim 2, referenced in Question 284 above, is settled on the basis of U&C, what amount will be assigned as the 'total network reimbursement cost that would have resulted from applying the Guaranteed Average Discount Percentage and

the Guaranteed Average Dispensing Fee per Prescription' as used in the incentive calculation described in Sections H.2.2 and H.2.3?

Response 285. The incentive is calculated on the entire benefit and reimbursement structure. The end result will be determined based on the difference between the actual cost to the Government and the contractor's proposed cost to the Government. Your question is based on an assumption that there is not a guaranteed dispensing fee. We cannot provide an answer based on an assumption contrary to the requirements of the solicitation.

Question 286. Will sales tax payments be considered in the 'actual network reimbursement cost' that is used in the incentive calculation described in Sections H.2.2 and H.2.3?

Response 286. No.

Question 287. Will sales tax be considered in determining the 'total network reimbursement cost that would have resulted from applying the Guaranteed Average Discount Percentage and the Guaranteed Average Dispensing Fee per Prescription' that is used in the incentive calculation described in Sections H.2.2 and H.2.3? That is, should guaranteed discounts and dispensing fee quotes reflect anticipated sale tax payments?

Response 287. No.

Question 288. Section H.2.3 states that Negative Incentive amounts will be deducted from future contractor payments, which might be interpreted to 'cap' the contractor liability at fees. However, the answer to question 76 states that there is no cap on the negative incentive fee. Is the contractor's potential liability for negative incentives limited in any way?

Response 288. No.

Question 289. 1. The RFP states only NCPDP version 5.1 is acceptable for data transmissions from the contractor to PDTS. Version 5.1 is specifically used for real time claim processing and we do not believe would be appropriate for paper claim processing. The 2642 claim form does not contain certain elements required for NCPDP v 5.1 and we believe NCPDP v 1.5 (batch submission) would be more appropriate for paper claim submissions to PDTS. Would the government consider requiring PDTS to accept NCPDP v 1.5 for paper claims?

Response 289. The RFP is correct; NCPDP version 5.1 will be used. The flexibility and variability of the standard will allow the Government to change certain fields commonly not available on the 2642 from a "required" field to a "captured" field.

Question 290. Certain supplies, such as lancets and acustrips used by diabetics, have no NDC. At the same time they are often submitted for reimbursement with other drugs or

supplies that do have an associated NDC. Today these claims are coded by MCS contractors as a medical service, non-drug line items. For the purpose of this RFP, will these services be reimbursed by the TRRx contractor or should they be transferred to the MCS contractor? If by the TRRx, how should they be submitted?

Response 290. Our intention is to reimburse these services through the TRRx Contractor. The Pharmacy Benefits Program Final Rule that implements the Uniform Formulary and the three tiered co-pay structure for DoD will clarify any coverage of specific supply items directly associated with the administration of medications. This process will standardize coverage, since some of these items are currently provided via the TRICARE Mail Order Pharmacy Contract and submitted to PDTS via NCPDP standards using default parameters established following contract award.

Question 291. In the current MCS contracts there have been several incidents where DEERS queries indicated a beneficiary was eligible and the contractor has paid in good faith and then found that DEERS has reversed the patient's eligibility, sometimes for more than a years worth of claim processing. In these incidents, when payments were made to the pharmacy, TMA General Counsel has ruled recoupments must be made against the pharmacy and it is the pharmacy's responsibility to seek out the patient to get their money back. Is this the manner in which TMA sees these incidents being handled for the TRRx contract? If so, could TMA provide statistics as to the frequency and dollar amount of such recoupment actions?

Response 291. Under TRRx, the contractor will seek recoupments from the beneficiary rather than the pharmacy. Direction on recoupment procedures are included in Section J, Attachment 3. TMA has no data relating to the volume of retail pharmacy recoupments that have occurred under the Managed Care Support contracts.

Question 292. The answer to question #84 makes reference to withholding the reversed amount from a future payment. Where is this practice defined in the RFP references? If it is not, will the government amend the RFP to include this requirement?

Response 292. Yes. Clarification has been provided at Section G.1.1.6. at Amendment 0001.

Question 293. The answer to question #112 states that for paper claims the eligibility will be determined with the nightly demographic download from DEERS and the answer to #93 states the contractor will not have to receive the demographic download or retransmit demographic data. How will the contractor be informed of the eligibility determination of beneficiaries submitting paper claims?

Response 293. The contractor will conduct an “E-1 eligibility inquiry” for paper claims to determine eligibility prior too processing the claim. The E-1 inquiry is a query to verify eligibility as of the date the service was rendered.

Question 294. If the contractor will not receive demographic data from DEERS it can use in conjunction with its processing of claims how will they determine which bank account from which to pay each claim (Tricare only eligibles from the Medicare Dual Eligibles)?

Response 294. This requirement was revised in Amendment 0001 removing that responsibility from the contractor.

Question 295. The RFP states the completion date is the date the prescription is filled AND the date the query is made to PDTS. These will not be the same for paper claims. What will be the date of completion when the query to PDTS is different than the filled date such as in paper submitted claims?

Response 295. For both initial and adjustment paper claims the Date the TED Record Processed to Completion as defined in the TRICARE Systems Manual should be used for the processed to completion date. This is the date the contractor processed the claim/treatment encounter data to completion. This is when all services and supplies on the claim have been adjudicated, payment has been determined, deductible has been applied, checks and EOBs have been prepared for mailing, and payment/deductible/denial has been posted to history and the TED record(s). This date does not change for resubmissions unless previously coded in error. This field should also be used for electronic claim adjustments made after the 10 day hold.

Question 296. The response to #115 indicates that a batch process will update CC&D. Please consider a case when a beneficiary is nearing the limit of their CC&D and a Point of Sale claim is submitted and CC&D is applied to the claim that satisfies their maximums. If on that same day and before the batch update is applied a Managed Care contractor processes a claim for that beneficiary and again applies CC&D so when the batch updates gets applied the person has exceeded the maximum limits. Who pays back the over applied CC&D the Pharmacy contractor or the Managed Care Contractor?

Response 296. Whichever contractor's data updated the CC&D last and caused the beneficiary to meet or exceed the cap would repay the over applied amount.

Question 297. Section C.3.2., states, "Achieve the highest level of beneficiary satisfaction possible through the provision pharmacy services." How will beneficiary satisfaction be measured?

Response 297. No formal measure of beneficiary satisfaction will occur as the beneficiary's main point of contact will be with the pharmacy. However, the Government will track the number of complaints regarding services provided that can be attributed to action or inaction on the part of the contractor and deal with those issues through the provisions of the contract.

Question 298. Section C.3.5., states, "Ensure retail pharmacy services delivered under this contract result in minimal disruption to DoD beneficiaries during transition and throughout the life of contract." Please define "minimal disruption."

Response 298. The Government does not have a quantified definition for minimal disruption. We would expect the contractor to implement and maintain a network of sufficient size to minimize disruption and maximize beneficiary convenience.

Question 299. C.7. TRRx Network Access Standards. The contractor shall maintain a pharmacy network which minimizes the number of eligible beneficiaries who will have to change pharmacies to use the offeror's proposed TRRx network. The network will be monitored using the reports in Section F.2.3. The contractor shall maintain a pharmacy network sufficient to meet the following minimum beneficiary access standards on an overall basis:
C.7.1. Urban: a pharmacy within two miles of 90% of the beneficiaries;
C.7.2. Suburban: a pharmacy within five miles of 90% of the beneficiaries;
C.7.3. Rural: a pharmacy within fifteen miles of 70% of the beneficiaries.

Is it acceptable to maintain pharmacy access that meets the above standards only in geographic areas where a retail pharmacy is available? For example, there are several rural areas in the United States that do not have any retail pharmacies available for contracting.

Response 299. The offeror must meet the standards listed in the solicitation on an overall basis, recognizing that disruption to beneficiaries will be considered in the best value determination.

Question 300. Section C.8.1., states, "The contractor shall accept and process all claims received from network and non-network pharmacies, and from beneficiaries for pharmaceuticals and supplies furnished in the 50 United States, the District of Columbia, Guam, the U.S. Virgin Islands and Puerto Rico. Pharmaceutical claims received for pharmaceuticals and supplies furnished in other locations shall be forwarded to the TRICARE contractor responsible for processing claims for those locations. The contractor shall ensure that each claim passes administrative claim processing edits as defined in the TRRx PDTS Interface Control Document (ICD) at Attachment 4, Section J. The contractor shall use the data provided by Defense Enrollment Eligibility Reporting System (DEERS) through PDTS to calculate beneficiary co-pay amounts and to determine the appropriate bank account from which to pay pharmacy claims, i.e., the Department of Defense Medicare Eligible Retiree Health Care bank account or the TRICARE bank account. The data from DEERS to calculate the co-pay amounts shall be provided to the contractor at the time filling the prescription is authorized. The demographic data from DEERS necessary to determine the appropriate bank account will be provided to the contractor two calendar days before PDTS submits the TRICARE Encounter Data (TED) record to TMA. The contractor shall match the DEERS data to the claim records, and provide the account data back to PDTS to be included in the TED record within one calendar day of receipt of the demographic data."

a. What concurrent edits, beyond DEERS eligibility coverage verification, will be performed by PDTS upon receipt of a retail claim transaction from the contractor (e.g., will PDTS use the initial transaction to apply DUR edits during the point of service transaction)?

b. What specific data element or elements will be passed by PDTS back to the contractor for use in calculating copayment amount?

c. Will PDTS' response transaction back to the contractor contain the actual copay dollar value that should be collected from the beneficiary, or will PDTS send back a code that the contractor uses to calculate copayment?

Response 300. a. Please refer to the PDTS ICD. All edits are defined within that document to include refill too soon, therapy duplications, quantity limits, PA and MN requirements, etc. Transactions will reject for administratively if the required data fields in the transaction itself (annotated as such in the ICD) are blank or not properly formatted.

b. PDTS will return the actual co-pay back to the Contractor in the paid claims response

c. Actual co-pay